



## PERSPECTIVES IN TREATMENT OF ATYPICAL BEHAVIOUR

- Ψ *Biological*
- Ψ *Cognitive*
- Ψ *Behavioural*
- Ψ *Psychodynamic*
- Ψ *Humanistic*

## PERSPECTIVES IN TREATMENT OF ATYPICAL BEHAVIOUR

### ***BIOLOGICAL APPROACH***

#### ***Basis of the Biological Approach to Treatment***

Therapies using biological treatments are based on the medical model of mental illness. This model suggests that abnormal behaviour is caused by a malfunction of some sort in the brain. Theorists adopting this approach believe that just as, say, lung and kidney disorders result from problems in the cells of these organs, mental disorders are linked to problems in brain cell functioning. These problems may be **anatomical** (the size or shape of some brain structures may be abnormal) or **biochemical** (the chemicals that enable neurons to operate may not work properly). Researchers suggest that such difficulties may be the result of various factors such as excessive stress, inherited metabolic disorders, infections, allergies, tumours, inadequate blood supply and physical trauma (Murphy & Deutsch, 1991).

There are a number of disorders that are almost certainly connected with specific problems in the brain (see **Organic Disorders** handout) and these are distinguished from **functional mental disorders** which are abnormal behaviour patterns without clear links to physical disorders in the brain. However, research has shown (e.g. Gershon & Rieder, 1992) that many so-called functional disorders (e.g. anxiety disorders, schizophrenia, depression) can be related to physical dysfunction in the brain and can be treated using biological treatments. Bear in mind that the research is still not completely clear-cut and many of these

disorders need some support from other kinds of therapies too. It is the case, though, that the former clear-cut distinction between organic and functional disorders is no longer used in leading classification and diagnosis systems such as ICD-10 and DSMIV.

To determine whether a disorder has a biological cause, apart from CAT, PET & MRI scans and blood tests, researchers will ask questions such as:

- ω Does the family have a history of that behaviour? (Genetic cause)
- ω Does the disorder seem to have a link with some illness or accident?
- ω Is the behaviour made worse by events that could be construed as having a physiological effect?

With these questions and the test evidence the practitioner is in a position to work out what the best biological course of treatment is.

### *The Treatments*

Biological therapists use physical and chemical methods to help people overcome their psychological problems. There are three major kinds of biological treatments, **drug therapy**, **Electroconvulsive therapy (ECT)** and **psychosurgery**:-

#### 1. *Drug Therapy*

The widespread use of this kind of therapy only dates back to the 1950s, when researchers discovered some **psychotropic drugs** (that act primarily on the brain and can help to alleviate symptoms of mental disorders). These drugs are now used widely and have revolutionised the treatment of some disorders. There are four major groups of psychotropic drugs:- **antianxiety**, **antidepressant**, **antibipolar** and **antipsychotic**.

- ⇒ Antianxiety drugs:- also called minor tranquillisers or anxiolytics. They reduce tension and anxiety. The first antianxiety drug was discovered in the late 1940s (Berger) and the most popular group of antianxiety drugs (the benzodiazepines, e.g. valium & Librium) was discovered in 1957. These are still the most widely prescribed drugs in the USA (Hollister, 1989). These drugs do seem to alleviate anxiety but they are addictive and have been overused and misused (Murphy et al, 1954). Used alone, without other support therapies, they are not enough to provide a long-term solution for anxiety.
- ⇒ Antidepressants:- they help lift the spirits of those who are depressed. The first kinds of antidepressants to be discovered were the **MAOIs** (Monoamine Oxidase Inhibitors) in 1957, followed shortly after by the **tricyclics** (1958). In the 1980s a third generation of antidepressants was discovered, chemically different in structure to the MAOIs and the tricyclics, called fluoxetine hydrochloride (tradenname **Prozac**). Tricyclics & Prozac have a 65% success rate, the MAOIs a 50% success rate (Montgomery et al, 1993). In addition, MAOIs have more serious side effects than the other classes, having the potential to cause high blood pressure, liver damage and even death if they are mixed with the chemical **tyramine** which is found in foods such as chicken, cheese, chocolate, beer, red wine and yoghurt. It does seem that the best possible outcome for depressed patients is to combine drug treatments with cognitive therapy, a combination which works better than either treatment alone (Hollon et al, 1993).
- ⇒ Antibipolar drugs:- these help stabilise the moods of people with bipolar mood disorder (see booklet). The most effective bipolar drug is **lithium**. This is a metallic element that occurs in nature as a mineral salt (Jefferson & Greist, 1989). It can reduce and

prevent manic and depressive episodes of bipolar mood disorder (Klerman et al, 1994). It is helpful in approximately 70-80% of cases (Prien, 1992). However, if the concentration is too high it can alter the body's sodium level and threaten life; this is not usually a problem though and this is one drug that truly has revolutionised the treatment of this disorder that was thought untreatable until the 1960s.

⇒ Antipsychotics:- these are also called **neuroleptic drugs** because they have unwanted effects similar to the symptoms of neurological diseases. However, they alleviate confusion, hallucinations and delusions and can put the patient back in contact with reality, some by blocking dopamine metabolism (the phenothiazines) and others by acting on different chemical such as serotonin (clozapine). The first kind of antipsychotics were the **phenothiazines** (Laborit, 1951; Delay & Deniker, 1952), the most frequently used being **chlorpromazine** (trade name Thorazine). More recently, other antipsychotic drugs have been developed such as haloperidol (Haldol) and a new drug called **clozapine** which, unlike the other drugs, does seem to have some effect on Type II schizophrenia. Research shows that antipsychotic drugs are by far the most effective treatment for schizophrenia (e.g. Klerman et al, 1994). However, for many patients, the drugs alone are not sufficient and need to be combined with some form of psychotherapy and support programmes. One of the major drawbacks with these drugs is the side effects which can be very serious. The most serious are movement disorders (e.g. shaking, bizarre contractions of the face and body, extreme restlessness, Tardive Dyskinesia - see booklet on schizophrenia); fortunately, the newer drugs, such as clozapine, do not seem to produce these effects (Meltzer, 1993).

## 2. *ECT*

This is a treatment still widely used today primarily on depressed patients (though in the past it has been used, to no great effect, on schizophrenics). It was first developed by two Italians (Cerletti & Bini) in the 1930s. Two electrodes are attached to a patient's forehead and an electrical current of 50-150 watts is briefly passed through the brain. The patient is anaesthetised during the process. The current causes a seizure (or convulsion) that lasts for up to a few minutes. After an average of 7-9 sessions the patient may feel considerably less depressed (Fink, 1988). ECT helps approximately 70-80% of depressed patients and it is used on tens of thousands annually (Foderaero, 1993). This is less than it used to be used in the past because the new drug treatments can make its use unnecessary. It tends to be used only when all other treatments have failed (Buchan, 1993), so could be seen as a "last resort" treatment. Ethically its use has been questioned mainly because no-one really knows *why* it works and it does involve a severe assault on the brain. Side effects include minor losses of memory and some mild confusion

## 3. *Psychosurgery*

This kind of treatment dates back a long way, to trephining (prehistoric practice of chipping hole in skull of person who behaved strangely). Modern forms are developed from a technique used by Moniz in the 1930s. The technique is **lobotomy**, which involves severing the connections between the frontal lobe and other areas of the brain. However, the technique did not work very well and caused dreadful side effects such as seizures, extreme listlessness and in some cases death (Barahal, 1958). Today's procedures are much more precise and have fewer unwanted effects, but they are used very infrequently, usually only after a disorder has continued for many years and all other treatments have been tried (Goodman et al, 1992).

### *Advantages of Biological Approach and Treatments*

1. It reminds us that psychological processes have a biological basis
2. With new techniques now available research into biological causes has progressed rapidly, producing valuable new information in a relatively short time.
3. The new medications that are continually being discovered have, without doubt, helped huge numbers of people after other interventions have failed. In particular, the treatment of schizophrenia, bipolar mood disorder and depression have been revolutionised by drug treatments (**Clozapine**, **lithium** and **prozac** respectively).

### *Problems with Biological Approach and Treatments*

1. Some of its supporters seem to have the idea that all human behaviour can be explained purely in biological terms and treated with biological methods. This narrow view limits rather than enhances our understanding of abnormal functioning and some critics argue that complex psychological problems can never be reduced to biological causes (Szasz, 1974). Although biological processes are the basis of all behaviour, in turn they are without doubt affected themselves by our behaviour, thoughts and emotions. For example, if we say that depression is caused by a shortage of a neurotransmitter, norepinephrine, it is possible that this shortage itself has been caused by some event that has happened to us in our past. It is probably much more useful and much more accurate to say that our mental life is an interplay of biological, psychological and environmental factors and it is important to examine this interplay rather than just focus on biological variables.
2. Evidence for biological causes of abnormal behaviour is often incomplete or inconclusive (Comer, 1995). For example, many neurological studies have been carried out on animals and we cannot be sure that animals experience things such as depression in the same way as humans. Therefore, biological insights drawn from such studies are uncertain and may not be relevant.
3. Similarly, genetic studies are open to many alternative interpretations. Evidence that certain disorders run in families may point to a genetic cause but it could also be that close relatives are more likely to experience similarly harmful psychological and environmental influences.
4. Some of the drugs used to treat disorders have severe side-effects that have to be weighed against the good they do (Wolfe et al, 1988). This is particularly a problem as clinicians, seeing drugs as a simple and often cost-effective way to treat patients with a mental disorder, will often overuse drugs and not fully consider alternative treatments. Even new so-called wonder drugs such as Prozac can cause aggressive and suicidal impulses (though the evidence for this is not definite).
5. Although drugs are effective in many cases, they do not help everyone (e.g. catatonic schizophrenics are often unresponsive to the phenothiazines used to successfully treat many Type I schizophrenics).
6. Some drugs used can be addictive (e.g. benzodiazepines) and weaning people off the drugs can be difficult and cause new problems for the patient.

7. Ethically, some of the treatments (e.g. ECT, psychosurgery) are on rather shaky ground because they involve invasive techniques and the reasons for their use & success (or lack of it) is often unclear. In particular, ECT has been called damaging and primitive (e.g. Goldman, 1988).

### KEY TERMS

|                      |                       |
|----------------------|-----------------------|
| medical model        | antipsychotics        |
| anatomical           | MAOI                  |
| biochemical          | tricyclics            |
| organic disorders    | lithium               |
| functional disorders | neuroleptic drugs     |
| Clozapine            | phenothiazine         |
| Prozac               | chlorpromazine        |
| ECT                  | Type I schizophrenia  |
| Psychosurgery        | Type II schizophrenia |
| psychotropic drugs   | lobotomy              |
| Antianxiety drugs    |                       |
| antidepressants      |                       |
| antibipolar          |                       |

### COGNITIVE APPROACH

#### Basis of the Cognitive Approach to Treatment

According to the cognitive model, to understand human behaviour, we must understand the content and process of human thought. When people display abnormal patterns of functioning, cognitive theorists assume that cognitive problems are to blame. Like the behaviourists they reject a medical illness view of abnormal psychological functioning. In the early 1960's two clinicians, Aaron Beck and Albert Ellis, proposed cognitive theories of abnormality.

#### Rational Emotive Therapy (Ellis)

Ellis proposes that each of us hold a unique set of assumptions about ourselves and our world that serve to guide us through life and determine our reactions to the various situations we encounter. Unfortunately, some people's assumptions are largely irrational, guiding them to act and react in ways that are inappropriate and that prejudice their chances of happiness and success. Ellis calls *these basic irrational assumptions*. Some people irrationally assume that they are failures if they are not loved by everyone they know - they constantly seek approval and repeatedly feel rejected. All their interactions are affected by this assumption, so that a great party can leave them dissatisfied because they don't get enough compliments. According to Ellis, these are other common irrational assumptions

- *The idea that one should be thoroughly competent at everything*
- *The idea that it is catastrophic when things are not the way you want them to be*
- *The idea that people have no control over their happiness*
- *The idea that you need someone stronger than yourself to be dependent on*
- *The idea that your past history greatly influences your present life*
- *The idea that there is a perfect solution to human problems, and it's a disaster if you don't find it.*

Ellis believes that people often forcefully hold on to this illogical way of thinking, and therefore employs highly emotive, techniques to help them vigorously and forcefully change this irrational thinking.

### **Beck's Cognitive Therapy**

Beck's approach is similar to Ellis in that it emphasises recognising and changing negative thoughts and maladaptive beliefs. Beck believes that a person's reaction to specific upsetting thoughts may contribute to abnormality. As we confront the many situations that arise in life, both comforting and upsetting thoughts come into our heads. Beck calls these unbidden cognition's *automatic thoughts*. When a person's stream of automatic thoughts is very negative you would expect a person to become depressed (*I'm never going to get this essay finished, my girlfriend fancies my best friend, I'm getting fat, I have no money, my parents hate me* - have you ever felt like this?) Quite often these negative thoughts will persist even in the face of contrary evidence.

In addition, Beck identifies a number of *illogical thinking processes* including:

- *selective attention: seeing only the negative features of an event*
- *magnification: exaggerating the importance of undesirable events*
- *overgeneralization: drawing broad negative conclusions on the basis of a single insignificant event*

These illogical thought patterns are self-defeating, and can cause great anxiety or depression for the individual.

### ***Treatments***

The cognitive therapist teaches clients how to identify distorted cognitions through a process of evaluation. The clients learn to discriminate between their own thoughts and reality. They learn the influence that cognition has on their feelings, and they are taught to recognise observe and monitor their own thoughts.

### ***Rational Emotive therapy***

Ellis is a direct and active therapist who tries to persuade clients that the rational-emotive perspective explains their difficulties. He points out their irrational assumptions in a blunt, confrontational and often humorous way, and then he models the use of alternative assumptions e.g. after criticising a man's perfectionist standards he may say "so what if you got a crap grade on your essay? It was only one essay - no more than that. It doesn't mean that you are useless!" Homework assignments are given so that clients can observe their assumptions, and to think of ways to test the rationality of these assumptions.

Rational emotive therapists have cited many studies in support of this approach. Most early studies were conducted on people with experimentally induced anxieties or non clinical problems such as mild fear of snakes (Kendall, Kendall & Kriss, 1983) but a number of recent studies have been done on actual clinical subjects and have also found that RET is often helpful (Lyons & Woods 1991). Anxiety?

### ***Beck's Cognitive Therapy***

Beck's system of therapy is similar to Ellis's, but has been most widely used in cases of depression. Cognitive therapists help clients to recognise the negative thoughts and errors in logic that cause them to be depressed. The therapist also guide clients to question and

challenge their dysfunctional thoughts, try out new interpretations, and ultimately apply alternative ways of thinking in their daily lives. Depressed people who are treated with Beck's approach improve significantly more than those who receive no treatment and about the same as those who receive biological treatments (Hollon & Beck 1994). Beck's Cognitive therapy has also been successfully applied to panic disorders and other anxiety disorders (Beck, 1993).

### **Differences between RET and Beck's Cognitive Therapy**

- Ellis views the therapist as a teacher and does not think that a warm personal relationship with a client is essential. In contrast, Beck stresses the quality of the therapeutic relationship.
- RET is often highly directive, persuasive and confrontive. Beck places more emphasis on the client discovering misconceptions for themselves.
- RET uses different methods depending on the personality of the client, in Beck's cognitive therapy, the method is based upon the particular disorder.

### ***Strengths of the Cognitive Approach and Treatments***

1. *Model has great appeal because it focuses on human thought.* Human cognitive abilities has been responsible for our many accomplishments so may also be responsible for our problems.
2. Cognitive theories lend themselves to testing. When experimental subjects are manipulated into adopting unpleasant assumptions or thought they became more anxious and depressed (Rimm & Litvak 1969))
3. Many people with psychological disorders, particularly depressive , anxiety , and sexual disorders have been found to display maladaptive assumptions and thoughts (Beck et al 1983).
4. Cognitive therapy has been very effective for treating depression, and moderately effective for anxiety problems.

### ***Weaknesses of the Cognitive Approach and Treatments***

1. The precise role of cognitive processes is yet to be determined. The maladaptive cognitions seen in psychologically disturbed people could be a consequence rather than a cause.
2. The cognitive model is narrow in scope - thinking is just one part of human functioning, broader issues need to be addressed.
3. Ethical issues: RET is a directive therapy aimed at changing cognitions sometimes quite forcefully. For some, this may be considered an unethical approach.

## ***BEHAVIOURAL APPROACH***

### **Basis of the Behavioural Approach to Treatment**

Behavioural theorists have a deterministic view of human functioning: they believe that our actions are determined largely by our experiences in life. They concentrate on specific behaviours, the responses that an organism makes to the stimuli in its environment, and on the principles of learning - the processes by which behaviours change in response to the environment. Many learned behaviours are adaptive, but abnormal and undesirable behaviours can also be learned.

The behavioural model was conceived in laboratories run by psychologists who were conducting experiments on conditioning (Pavlov, Watson, Skinner). Efforts to modify abnormal behaviours by means of conditioning were made as early as the 1920s. It was not until decades later that these principles were applied in clinical practice when many clinicians were becoming disenchanted with the imprecision of the Psychodynamic model. The behavioural model has developed into an approach with three branches: classical conditioning, operant conditioning, and modelling.

### **Classical Conditioning explanations of abnormal behaviour**

You should remember the basics of classical conditioning from PS1! Basically, two events that repeatedly occur close together in time become fused in a person's mind and before long the person respond in the same way to both events. Remember Pavlov's experiment?

1.      Food -----                      salivation  
         UCS                                      UCR
  
2.      Food + Bell --- salivation  
         UCS        CS                      UCR
  
3.      Bell -----                      salivation  
         CS                                      CR

Abnormal behaviours can be explained in this way. Imagine a young boy who is repeatedly frightened by the neighbours Rottweiler, who barks and snarls every time he walks by. The boy's parents can understand his fear of dogs, but can't understand why he is afraid of sand, and cries hysterically every time they go to the beach. It turns out that the neighbours have a big sand pit for the dog to play in - every time the dog snarls, the sand is there too. So by association the child comes to fear sand as much as the dog. This fear response may persist throughout life if the child becomes so good at avoiding sand that he never learns how harmless it is.

### **Operant conditioning explanation of abnormal behaviour**

In operant conditioning humans learn to behave in certain ways because they receive reinforcements (which strengthen behaviours) or punishments (which weaken behaviour). Behaviourists believe that many human behaviours are learned by operant conditioning - children acquire manners by receiving praise and attention, or are punished for undesirable behaviours. Many abnormal behaviours may develop as a result of reinforcement. Some people may learn to abuse alcohol and drugs because initially such behaviours brought feeling of calm and pleasure (Coner, 1951). Others may exhibit bizarre behaviours because they enjoy the attention they get. A number of studies show that when bizarre talk of schizophrenic patients are consistently ignored by hospital personnel and appropriate behaviours rewarded with privileges, many patients begin to show marked changes for the better (Braginsky & Braginsky, 1969).

### **Modelling explanation of abnormal behaviour**

Modelling is a form of learning in which individuals acquire responses through observation and imitation (Bandura 1977). Behaviourists believe that many everyday human behaviours are learnt through modelling: children may acquire language, facial gestures etc. by imitating the behaviours of their parents. Abnormal behaviours can be acquired too - remember how children learnt aggressive behaviours from Bobo the clown? Similarly, children of poorly functioning people may themselves develop maladaptive reactions because of their exposure to inadequate parental models.



## ***Treatments***

A hallmark of behaviour therapy is the identification of specific goals at the outset of the therapeutic process. In helping clients achieve their goals, behaviour therapists typically assume an active and directive role. Although the client generally determines what behaviour will be changed, the therapist typically determines how this behaviour can best be modified. Some critics characterise the relationship between the behaviour therapist and client as manipulative and impersonal, however most modern behaviourists agree that a good therapeutic relationship increases the chance that the client will accept the therapy (Spiegler 1893). Therapists can employ a number of techniques including relaxation training, systematic desensitisation, modelling methods, assertion-training programmes and self-management programmes.

### ***Systematic desensitisation***

This is a classical conditioning treatment intended to change clients reactions to stimuli. It is a process of teaching phobic clients to react calmly instead of with intense fear to the objects or situations they dread. The step by step procedure begins with teaching them the skill of deep muscle relaxation over the course of several sessions. The clients then construct a *fear hierarchy*, starting with the situations/objects that are minimally feared and ending with those most fearsome. Therapists then have the clients either imagine or physically confront each item on the hierarchy while they are in a deep state of relaxation. Step by step they move up the hierarchy until they can relax in the presence of all the vents that had previously aroused fear. Research has found systematic desensitisation to reduce phobic reactions more effectively than placebo treatments or not treatment at all (Emmelkamp, 1994). These approaches have also been helpful in treating several other kinds of problems including sexual dysfunctions, posttraumatic stress disorders, agoraphobia, and asthma attacks (Emmelkamp, 1994; Steinmaker & Borkovec, 1974).

### ***Flooding /Implosive Therapy***

Flooding therapist believe that clients will stop fearing things when they are exposed to them repeatedly and made to see that they are actually quite harmless. Phobic patients are forced to confront what they fear so they will see that no real danger exists. No relaxation training or graduated approach is used, and the flooding can either be imaginal or in vivo. In view of the intensity of implosive therapy, and the suddenness with which clients are exposed to the stimuli they fear, some clinicians hold that the procedure may do further damage to clients and should be considered only as a last resort. However if conducted properly it is more likely than most forms of treatment to help clients overcome their phobias. A single implosive therapy session was administered to 21 subjects who were extremely fearful of rats, during which the therapist had them imagine scenes in which they touched rats, were clawed by rats etc. (Hogan & Kirchner 1967). After this treatment 20 of the subjects could open a rats cage, and 14 could actually pick a rat up. In vivo flooding is more effective than imaginary flooding.

### ***Token economy***

Based on operant conditioning principles of reinforcing good behaviour by reward, and weakening undesirable behaviour by punishing. This technique has been employed successfully with those patients experiencing psychosis (Glynn 1990). When these patients talk coherently and behave normally they are rewarded with food privileges or attention. Conversely they receive no rewards when they speak bizzarely or display other psychotic behaviours. Operant conditioning techniques work best in institutions or schools where a person's behaviour can be reinforced systematically throughout the day. The programs are referred to as token economy programmes because in many of them desirable

behaviour is reinforced with tokens that can later be exchanged for food, privileges or other rewards. In a study carried out in a classroom by Aylon & Roberts (1974) reading accuracy increased from 40-85% when children earned tokens when they did well on daily reading tests.

### ***Modelling techniques***

The basic design is for therapist to demonstrate appropriate behaviours for clients, who through a process of imitation and rehearsal acquire the ability to perform the behaviours in their own lives. In some cases, therapists model new emotional responses for clients e.g. calmly handling snakes to show that it is possible to be relaxed under such conditions. Modelling of emotion can be quite effective in the treatment of phobic disorders (Rosenthal & Bandura 1978). Modelling has also been used in combination with other techniques to help people improve their social skills (social skills training). eg. clients point out the social deficits of clients and then role-play social situations with the clients. Therapists have successfully taught social and assertion skills to shy passive or socially isolated people, as well as to people who have a pattern of bursting out in rage or violence (Emmelkamp 1994). The approach has also been used to improve the social skills of people who are depressed, alcoholic, obese, or anxious (Cooney et al. 1991)

### ***Strengths of the Behavioural Approach and Treatments***

1. Behavioural explanations and treatments can be tested in the lab. The results have lent considerable support to the behavioural model (Emmelkamp 1994, Wolpe 1987)
2. Experimenters have successfully used the principles of conditioning to create a number of clinical symptoms in laboratory subjects, thus suggesting that mental disorders may arise in this way
3. Clinicians have successfully employed behavioural techniques to help change a variety of clinical problems. These include anxiety disorders (phobias), depression, sexual disorders, prevention and treatment of cardiovascular disease.
4. Effectiveness is considerable when compared to the relatively short duration and low overall cost of therapies

### ***Weaknesses of the Behavioural Approach and Treatments***

1. Although researchers have induced specific symptoms through conditioning, they have not established that such symptoms are usually acquired in this way.
2. Recent research shows that subjects can acquire behaviours that contradict the basic principles of conditioning (Rescorla 1988).
3. The behavioural perspective is simplistic - it overlooks the human capacity to think critically. Some behaviourists have recognised the need to look at cognitive behaviours and have developed cognitive behavioural theories (eg. Meichenbaum 1993.)
4. Improvements through therapy do not always extend to the person's real life, and do not necessarily maintain themselves without further behavioural intervention.
5. Behavioural therapies are not effective with psychological disorders that are broad or vaguely defined.
6. Ethical issues: It may be considered unethical to impose token economy programmes and other operant conditioning techniques without the clients permission.

## **PSYCHODYNAMIC APPROACH**

### **Basis of the Psychodynamic Approach to Treatment**

The psychodynamic approach to atypical behaviour and abnormality emphasises the role of feelings, conflicts and drives operating at conscious and unconscious levels, in contrast with the biological approach which views the person as an essentially biological being and in contrast with the behavioural approach which is little concerned with understanding reasons or any mediational process. This approach is sometimes referred to as depth psychology.

Psychodynamic theorists maintain that all behaviour whether 'normal' or 'abnormal' arises from underlying psychological forces. These inner forces interact with each other and are often in conflict with each other, hence the term *dynamic*. Their interaction gives character to the personality producing differences between individuals in the extent to which we are successful in resolving these conflicts. Abnormality and normality then are on the same continuum in the sense that we all experience intrapsychic conflict but abnormal behaviours or symptoms arise when the person is particularly unsuccessful in resolving the conflicts, resulting in anxiety or neurosis.

There are various schools of psychodynamic psychology, all beginning with the work of Sigmund Freud but each adopting other names for their doctrines to indicate deviations from Freudian theory.

| <b>Psychodynamic Approaches</b> |                              |                              |  |   |
|---------------------------------|------------------------------|------------------------------|--|---|
| <b>Psychoanalysis</b>           | <b>Analytical Psychology</b> | <b>Individual Psychology</b> | <b>Ego Analysis or Ego Psychology</b>                            | <b>Object Relations</b>   |
| <i>Sigmund Freud</i>            | <i>Carl Jung</i>             | <i>Alfred Adler</i>          | <i>Anna Freud</i><br><i>Karen Horney</i><br><i>Heinz Hartman</i> | <i>Melanie Klein</i><br><i>Otto Kernberg</i><br><i>D.W. Winnicott</i> |

The **main concepts** within Freudian **psychoanalysis** (covered in Ps1 - check your knowledge of these) are:

- the struggle between Eros and Thanatos (the life and death drives)
- the tripartite structure of the personality (id, ego and super-ego)
- the dynamics of the unconscious
- the role of anxiety (neurotic, realistic and moral) and of defence mechanisms
- the processes of psychosexual development, from oral through anal, phallic and latency to the genital stage

### **Psychoanalytic Treatment**

Following the assumptions of psychoanalytic theory, psychoanalysts view current psychological difficulties as arising from earlier childhood emotional trauma. Each personal history is the history of a series of conflicts, some of which we may be aware, the majority of which we will be totally unaware due to the operation of defence mechanisms. Freud believed that psychological disorders arise from intrapersonal conflicts of which we are unaware, conflicts which have been repressed to the unconscious.

Particularly important conflicts in Freud's view are the conflicts between the ego and super-ego and between Eros and Thanatos, that is, between the sexual and aggressive drives. The key assumption here is that a person's present disorder can be successfully resolved only by understanding their unconscious basis in the early relationships with parents.

**The aims of psychoanalysis** therefore, are:

- to free the id's impulses from excessive control by the ego
- to strengthen the ego
- to alter the contents of the super-ego so that it becomes less oppressive and more accepting

These amount to a *re-education of the ego*. Freud considered this possible and effective for a range of disorders in which the person has a degree of appreciation of reality, such as anxiety disorders like phobias, anorexia, bulimia and depression as well as obsessive compulsive disorders. He did not think it would help the psychotic (although some therapists claim success with personality disorders e.g. C.B. Wilbur's (1970) case of *Sybil*) but could be used with the neurotic. The neurotic is someone who uses defence mechanisms excessively and whose libido gains expression through bodily symptoms such as slips of the tongue and other 'mistakes' (so-called **parapraxes**), ritualistic compulsions, temporary paralyses and so on. The neurotic has a distorted perception of reality and in order to remove the symptoms must gain access to the repressed feelings that give rise to them. By gaining this insight, the conflict will be reduced or resolved and the symptoms removed. This is the *recovery of unconscious memories*, achieved by various techniques.

### ***Therapeutic Techniques and Procedures***

Due to the nature of defence mechanisms and the inaccessibility of the deterministic forces operating in the unconscious, psychoanalysis in its classic form is a lengthy process often involving 2 to 5 sessions per week for several years. This approach assumes that the reduction of symptoms alone is relatively inconsequential as if the underlying conflict is not resolved, more neurotic symptoms will simply be substituted. The analyst typically is a 'blank screen', disclosing very little about themselves in order that the client can use the space in the relationship to work on their unconscious without interference from outside. The psychoanalyst uses various techniques as encouragement for the client to develop insights into their behaviour and the meanings of symptoms, including *free association*, *interpretation (including dream interpretation)*, *resistance analysis* and *transference analysis*.

**Free-association** is where the client simply tells everything that occurs to consciousness without attempting to edit it in any way.. Sometimes stimulus material may be used such as words or images but the main idea is for the client to find a way of lifting repressions. Nothing the client says is taken at face-value. In fact, the more rational it is, the more likely it is to be covering up or repressing something meaningful at an unconscious level. Clues to the nature of repressed material are given by attempts to change subject, significant omissions, forgetting or losing track.

**Interpretation** is used by the analyst offering suggestions for the meaning of some of the client's behaviours. It is a hypothesis, not a definitive solution to the problem and the client's response to the interpretation can often be more indicative of unconscious motives than the actual interpretation itself. The client needs to be close to the point of accepting an interpretation before it is offered, otherwise the suggestion itself will meet with resistance and will be rejected, twisted or distorted in some other way. Saretsky (1978) maintains that the analyst must learn to be sensitive to the client's level of readiness to consider the

interpretation, when the repressed material is already near to consciousness. The analyst is working here with the client's ego, trying to get it to overcome resistances and to fill in the gaps in memory. It is often best for the analyst to point out that a resistance is operating than to try to offer an interpretation of why the client is resisting. Material for interpretation may come from free association or there may be the **interpretation of dreams**. Freud considered dreams to be the 'royal road to the unconscious' as it is in dreams that the ego's defences are lowered so that some of the repressed material comes through to awareness, albeit in distorted form. Freud distinguishes between the **manifest content** of the dream, the consciously remembered material, and the **latent content**, the symbolic meaning of the dream. Dream interpretation involves the translation of the (inevitably distorted) manifest content into the (truthful) latent meaning. Understanding the various distorting processes would help us to understand the latent meaning of a dream. The process of **condensation** is the joining of two or more idea/images into one. For example, a dream about a man may be a dream about both one's father and one's lover. A dream about a house might be the condensation of worries about security as well as worries about one's appearance to the rest of the world. The process of **concretization** is the representation of abstract ideas by using concrete images. For example, a dream about a king might represent the abstract ideas of authority or wealth. The process of **symbolic representation** is when one image stands for another, so a dream about a king may be a dream about a father.

**Resistance analysis** is the analysis of the conscious efforts of the ego to avoid the conflicts and challenges to those conflicts. The more threatening the repressed material is, the more the ego resists accepting it. All the forces that oppose the client's getting better are resistance. There are several types of resistance:

One kind is repression resistance, resisting reproducing unconscious material.

Another is transference resistance is refusing to acknowledge that the client feel some emotions towards the analyst which are similar to emotions buried in the unconscious.

Another is the client's refusing to admit that something could be gained by removing symptoms.

Another is where the id refuses to be re-directed into more acceptable forms of gratification.

Another arises from the super-ego, the resistance shown by guilt at the prospect of any recovery or improvement.

Freud considered the struggle to overcome resistances as the main work of psychoanalysis and the one which analysts find most difficult.

**Transference analysis** is the understanding of the relationship that develops between the analysand(client) and the analyst. The analyst's role is to remain neutral but to encourage an environment in which unconscious material can be explored. This often means that one way for the analysand to examine emotions towards significant figures in their past is to transfer the emotions into the psychoanalytic relationship. So the client may feel hostile or loving towards the analyst, which is really an emotion displaced from its legitimate target. Most often the analysand will fall deeply in love with the analyst, reflecting strong feelings towards a parent which have not been allowed expression directly previously. Of course, although this is experienced by the client as real and in a sense is real, it is also mis-directed and so unreal. It is nevertheless a step towards accepting the legitimate feeling towards the original focus of the emotion. The transference often starts by being positive but as the therapist maintains a realistic distance, will be increasingly frustrating for the client who may then come to transfer associated feelings of hostility into the relationship. Handling this transference is a vital skill of a psychoanalyst who will eventually point to an interpretation as to the origin of the emotions. An associated emotion is **counter-transference** where the

therapist projects some of their own feelings into the relationship with the client, hopefully with a significant degree of insight as to their bogus origin.

### *Applications of Psychoanalysis*

Psychoanalysis (along with Rogerian humanistic counselling) is an example of a **global therapy** (Comer 1995 p 143) which has the aim of helping clients to bring about major change in their whole perspective on life. This rests on the assumption that the current maladaptive perspective is tied to deep-seated personality factors. Global therapies stand in contrast to approaches which focus mainly on a reduction of symptoms, such as cognitive and behavioural approaches, so-called **problem-based therapies**.

**Anxiety disorders** such as phobias, panic attacks, obsessive-compulsive disorders and post-traumatic stress disorder are obvious areas where psychoanalysis might be assumed to work. The aim is to assist the client in coming to terms with their own id impulses or to recognise the origin of their current anxiety in childhood relationships that are being relived in adulthood. Svartberg and Stiles (1991) and Prochaska (1984) point out that the evidence for its effectiveness is equivocal. Salzman (1980) suggests that psychodynamic therapies generally are of little help to clients with specific anxiety disorders such as phobias or OCDs but may be of more help with general anxiety disorders. Salzman (1980) in fact expresses concerns that psychoanalysis may increase the symptoms of OCDs because of the tendency of such clients to be overly concerned with their actions and to ruminate on their plight (Noonan 1971).

**Depression** may be treated with a psychoanalytic approach to some extent. Psychoanalysts relate depression back to the loss every child experiences when realising our separateness from our parents early in childhood. An inability to come to terms with this may leave the person prone to depression or depressive episodes in later life. Treatment then involves encouraging the client to recall that early experience and to untangle the fixations that have built up around it. Particular care is taken with transference when working with depressed clients due to their overwhelming need to be dependent on others. The aim is for clients to become less dependent and to develop a more functional way of understanding and accepting loss/rejection/change in their lives. Shapiro et al (1991) report that psychodynamic therapies have been successful only occasionally. One reason might be that depressed people may be too inactive or unmotivated to participate in the session. In such cases a more directive, challenging approach might be beneficial. Another reason might be that depressives may expect a quick cure and as psychoanalysis does not offer this, the client may leave or become overly involved in devising strategies to maintain a dependent transference relationship with the analyst.

### *Evaluation of the Psychodynamic Approach and Treatments*

*Fisher and Greenberg (1977), in a review of literature, conclude that psychoanalytic theory cannot be accepted or rejected as a package, 'it is a complete structure consisting of many parts, some of which should be accepted, others rejected and the others at least partially reshaped'.*

*Fonagy (1981) questions whether attempts to validate Freud's approach through laboratory tests have any validity themselves. Freud's theory questions the very basis of a rationalist, scientific approach and could well be seen as a critique of science, rather than science rejecting psychoanalysis because it is not susceptible to refutation.*

*The case study method is criticised as it is doubtful that generalisations can be valid since the method is open to many kinds of bias. However, psychoanalysis is concerned with offering interpretations to the current client, rather than devising abstract dehumanised principles. Anthony Storr (1987), the well-know psychoanalyst appearing on TV and Radio 4's 'All in the Mind', holds the view that whilst a great many psychoanalysts have a wealth of 'data' at their fingertips from cases, these observations are bound to be contaminated with subjective personal opinion and should not be considered scientific. He goes on to point out, however, that attempts to understand humans as mere responders to stimuli is unscientific since it offers no explanation of processes involved.*

## **HUMANISTIC APPROACH**

### ***Basis of the Humanistic Approach to Therapy***

The humanist approach is based on the work of **Carl Rogers** (1902 - 1987). His view differs sharply from the psychodynamic and behavioural approaches in that he suggested that clients would be better helped if they were encouraged to focus on their current subjective understanding rather than on some unconscious motive or someone else's interpretation of the situation. He strongly believed that in order for a client's condition to improve **therapists should be warm, genuine and understanding**. The starting point of the Rogerian approach to counselling and psychotherapy is best stated by Rogers (1986) himself.

*"It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behaviour - and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided."*

Rogers **rejected the deterministic nature of both psychoanalysis and behaviourism** and maintained that we behave as we do because of the way we perceive our situation. "As no one else can know how we perceive, we are the best experts on ourselves." (Gross 1992)

Believing strongly that theory should come out of practice rather than the other way round, Rogers developed his theory based on his work with emotionally troubled people and claimed that we have a remarkable capacity for self-healing and **personal growth** leading towards **self-actualization**. He placed emphasis on the person's current perception and how we **live in the here-and-now**.

Rogers noticed that people tend to describe their current experiences by referring to themselves in some way, for example, "I don't understand what's happening" or "I feel different to how I used to feel". Central to Rogers' theory is the notion of self or **self-concept**. This is defined as "**the organized, consistent set of perceptions and beliefs about oneself**". It consists of all the ideas and values that characterize 'I' and 'me' and includes perception and valuing of 'what I am' and 'what I can do'. Consequently, the self-concept is a central component of our total experience and influences both our perception of the world and perception of oneself. For instance, a woman who perceives herself as strong may well behave with confidence and come to see her actions as actions performed by someone who is confident.

The self-concept does not necessarily always fit with reality, though, and the way we see ourselves may differ greatly from how others see us. For example, a person might be very interesting to others and yet consider himself to be boring. He judges and evaluates this image he has of himself as a bore and this valuing will be reflected in his **self-esteem**. The

confident woman may have a high self-esteem and the man who sees himself as a bore may have a low self-esteem, presuming that strength/confidence are highly valued and that being boring is not.

According to Rogers, we want to feel, experience and behave in ways which are consistent with our self-image and which reflect what we would like to be like, our **ideal-self**. The closer our self-image and ideal-self are to each other, the more consistent or **congruent** we are and the higher our sense of self-worth. A person is said to be in a state of **incongruence** if some of the totality of their experience is unacceptable to them and is denied or distorted in the self-image. **Incongruence is "a discrepancy between the actual experience of the organism and the self-picture of the individual insofar as it represents that experience."** As we prefer to see ourselves in ways that are consistent with our self-image, we may use **defence mechanisms** like denial or repression in order to feel less threatened by some of what we consider to be our undesirable feelings. A person whose self-concept is incongruent with her or his real feelings and experiences will defend because the truth hurts. For example, a person on occasion may feel possessive but not want to see herself or himself as possessive. Possessiveness will therefore be pushed out of awareness, leaving a self-image of a generous person, not at all possessive. Here is an example from Rogers;

*"[An] instance would be the mother who develops vague illnesses whenever her only son makes plans to leave home. The actual desire is to hold on to her only source of satisfaction. To perceive this in awareness would be inconsistent with the picture she holds of herself as a good mother. Illness, however is consistent with her self-concept, and the experience is symbolized in this distorted fashion. Thus...there is a basic incongruence between the self as perceived (in this case as an ill mother needing attention) and the actual experience (in this case a desire to hold onto her son)."*

The total experiencing individual including all feelings and experiences, denied or accepted, is called the **organismic self** by Rogers. The greater the gap between the organismic self and the self-concept, the greater the chance of confusion and maladjustment and the lower the person's ability to function satisfactorily. The self-concept of the *congruent, fully-functioning person*, however, reflects the inevitability of change that occurs in the environment and is therefore, flexible.

Similarly, as stated above, the closer the ideal-self is to the self-image (i.e. the closer the person you would *like* to be is to how you see yourself), the more fulfilled and happier the person will be. So, we can see that **two kinds of incongruence** can develop:

- i) incongruence between self-concept and organismic self
- ii) incongruence between ideal-self and self-image.

How do these incongruences develop? Rogers believed that we need to be regarded positively by others, we need to feel valued, respected, treated with affection and loved. If someone accepts us and everything we are, faults and all, they set no conditions on respecting or loving us. Rogers calls this **unconditional positive regard** and he believes that a major consequence of being totally accepted by others is total acceptance of ourselves by ourselves. This would mean that we accept our organismic experiences and there is no incongruence. However, if significant others offer only conditional positive regard, valuing us only when we behave, think or feel as they want us to behave, think or feel, we are most likely to do those things which please them. This will lead to our being valued by others but only on condition that we deny otherwise valid personal experiences. For example, you may



feel jealous of a younger sibling or threatened by an older sibling and these feelings may be perfectly valid. However, a parent may be disapproving of this and reject you if you feel like this, making their acceptance of you conditional on something. You will need to incorporate this into your self-concept and may decide that you are wrong to feel as you do (because a parent says so) and so may feel ashamed (perhaps a feeling you imagine a parent would expect). You may feel less ashamed if you behave in an approved of manner and so you may behave, think and feel solely in a way that pleases others in order to get their approval, such as acting lovingly, believing you must like your sibling and feeling affectionate towards that person.

As a result of the way significant others respond, a person may develop an imagined or idealised set of **conditions of worth**, standards used to judge what kinds of behaviours would gain the approval of others. When we behave according to conditions of worth, we create an incongruence between organismic self and self-concept. Similarly, if the standards are unrealistically high, we create an incongruence between ideal-self and self-image, feeling that we are never good enough. "Our need to be loved and accepted can impair our ability to be 'congruent', to be whole and genuine."

### *Approaches to Treatment*

There is an almost total absence of techniques in Rogerian psychotherapy due to the unique character of each counselling relationship. Of utmost importance, however, is the quality of the relationship between client and therapist. "The therapeutic relationship...is the critical variable, not what the therapist says or does." In order to enhance congruence and move towards self-actualization the person needs to be self-accepting and to **replace the conditions of worth** with truer, organismic values. This is established according to Rogers by having at least one relationship in which the person experiences unconditional positive regard, where the person is totally accepted and supported regardless of what they do, think or feel. The relationship obviously must be controlled or directed not by the other person in the relationship but by oneself. The person himself or herself is at the centre, hence the term 'person-centred'.

Any relationship which reduces incongruence is a **therapeutic relationship** according to Rogers. Such a relationship is **characterized by** one person experiencing another person who communicates:

- a) **unconditional positive regard**
- b) **empathy** (i.e. "sensing accurately the feelings and personal meanings the client is experiencing and communicating this acceptant understanding to the client.")
- c) **genuineness** (realness or congruence i.e. being oneself rather than playing a role of, say, therapist, friend, parent or teacher)

If a person demonstrates these three qualities consistently in a relationship, they are offering a therapeutic context to the other person. If a person feels these three qualities in a relationship, they are said to be in a therapeutic, healing or growing relationship. Typically this happens in a counselling situation but is not exclusive to counselling. A person can experience such qualities only if they are effectively communicated and so much of Rogers' work focuses on communicating accurately and honestly with each other. This entails really listening to what someone else is saying/feeling without your own experiences, expectations or 'baggage' blocking the way.

According to Rogers (1959) the following are the **necessary and sufficient conditions for therapy** to occur:

- a) "that two persons are in *contact*
- b) that the first person, whom we shall term the client, is in a state of *incongruence*, being *vulnerable*, or *anxious*.
- c) that the second person, whom we shall term the therapist, is *congruent in the relationship*.
- d) that the therapist is *experiencing unconditional positive regard* toward the client
- e) that the therapist is *experiencing an empathic* understanding of the client's *internal frame of reference*.
- f) that the client *perceives*, at least to a minimal degree, conditions 4 and 5, the *unconditional positive regard* of the therapist..., and the *empathic* understanding of the therapist."

The **goals** of Rogerian counselling seem to arise out of Rogers' assumption of the actualizing tendency and his political view of the person as having the right to self-determination. The overall goal is for the person **to become 'fully functioning'** which may mean for some clients a total revision of their world-view and outlook. Such a person is characterized by being essentially optimistic, engaged in life, not defensive, accepting of themselves and of others, accepting responsibility and being creative in approaching life, prizing themselves and others and relating to the here-and-now in an undistorted way, savouring the richness. These attributes play a role in personal growth as well as being an end in themselves. As Nelson-Jones puts it, "these attributes are both the ends and the means of the actualizing tendency and all involve effective self-conceptions. Self-actualizing people possess actualizing self-concepts!"

When the conditions Rogers (1959) outlines are met, the **process of therapy** begins which has these characteristics: the client...

- a) is increasingly free in expressing feelings
- b) expresses feelings which increasingly have reference to the self, rather than non-self
- c) expresses feelings which increasingly acknowledge incongruity between experiences and self-concept
- d) is more aware of the disadvantages of incongruence
- e) experiences in full awareness feelings that previously were unavailable to awareness
- f) is more able to incorporate these feelings into self-concept
- g) increasingly feels unconditional self-regard
- h) is more and more self-accepting

If there are any **techniques** they are listening, accepting, understanding and sharing, which seem more attitude-orientated than skills-orientated. In Corey's (1991) view "a preoccupation with using techniques is seen [from the Rogerian standpoint] as depersonalising the relationship." The Rogerian client-centred approach puts emphasis on the person coming to form an appropriate understanding of their world and themselves.

### ***Evaluation of the Humanistic Approach***

- In terms of evaluation, this approach is very optimistic view about human nature. Is Rogers right to assume that we all have this tendency for self-growth? Psychoanalysis in contrast places significant emphasis on conflict within the person and points to the potential we have to destroy as well as to create. It could be argued that Rogers is either naive or perhaps in denial.
- Rogers (1957) refers to a range of counselling and therapies in securing evidence for these conditions across different approaches. It is not only practising Rogerians then

who demonstrate these qualities. If there is satisfactory progress in any therapy then these conditions should be met, regardless of the explicit goals of those approaches. There is considerable evidence, especially from the behavioural approaches, that the client's subjective content including feelings of worth etc., is not immediately relevant to behavioural change in the direction of preferred functioning (however the latter may be defined). This seems to ignore one of Rogers' main assertions that humans have a strong tendency towards growth. If someone is in a systematic desensitization programme, for example, then clear as they and their therapist may be that a successful outcome must be measurable in behavioural terms there must also be an implication that attitudes are held towards those outcomes which entails a role is played by subjective content.

- We need to ask whether it is in fact possible to demonstrate the Rogerian triad of unconditional positive regard, empathy and genuineness in a relationship and yet be consistent. Some of the genuineness might occasionally entail expressing negative feelings towards the client and whilst Rogers might say don't generalise from feeling negative about such-and-such to feeling negative about the client in more global terms, this ignores the significant role that perceptual set can have in influencing how we perceive our global world, including our client.
- 'Person-centred' entails emphasizing the individual rather than the context in which the individual exists. This puts the person back into the picture, something which skills orientated approaches seem to neglect as pointed out above. However, the feminist psychotherapists Dobash and Dobash (1992) point out that the emphasis on changing the individual seems to assume that anything less than fully functioning is unsatisfactory and the person has a responsibility to themselves to change themselves. This emphasis on changing oneself to make things better might amount to an undermining of the person, a *disempowering* rather than the empowering that Rogers advocates. They argue that the approach ignores the socio-political context in which the client lives. It might be the case, for instance, that there is a legitimacy to the way the person feels, for example if they have been abused or are harassed. A more valuing approach to the person might be to focus on action for changing the situation or context. Is it appropriate to assume that all restrictions to being fully functioning in society are the individual's problem? Or is it appropriate to demand that the system, be it the relationship, job or society in which the person is living should change instead?